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ABSTRACT

It has been argued that traditional psychiatric labels, hospitalization, anti-psychotic medication, and associated assistance programs tend to reinforce and perpetuate a sense of helplessness and dependency among mental patients. To investigate feelings of power and dependency of 15 neuropsychiatric patients in a sheltered workshop, self-evaluations of dependency were assessed in relation to a real-life role and power feelings were assessed in relation to another role. Although the results indicated that dependency and power feelings were independent of each other, the data revealed that dependency feelings positively predicted the number of mental hospital admissions and that feelings of power in the workshop negatively predicted work performance. The findings provide direct evidence that dependency and power can be role-specific. (Author/JAC)

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Concurrent Feelings of Power and Dependency in a Sheltered Workshop for Chronic Neuropsychiatrics

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It has been argued (Szasz, 1960) that traditional psychiatric labels, hospitalization, anti-psychotic medication and associated assistance programs tend to reinforce and to perpetuate a sense of helplessness and dependency among mental patients. Certain forms of therapeutic intervention may, ironically, contribute more to the problem than to the solution. While this view has enjoyed some popularity in the last decade or so, today, it seems to be less subscribed to than at previous times. Several factors can be postulated to explain the apparent predominance of medical model: 1) It is easier to precribe medication and supplemental assistance than to try and change peoples' living circumstances; 2) Medication and hospitalization generally provide more immediate effects; and 3) Most clinicians would generally prefer to "psycho-talk" to neurotics and to medicalize psychotics, since the former are more likely to get better and to pleasantly pay their bills, while the latter are more likely to not get better and to insult, resist, worry and even attack the clinician. Whatever the exact cause or reasons, the medical model of mental illness continues to predominate, especially in mental hospital settings.

Still the social psychological argument remains that we would probably do better to de-emphasize labeling, attempt to keep even the severely disturbed within the community, encourage economic independence, and rely less upon medical solutions and more upon social psychological ones. Some of the most compelling support for such social psychological arguments have in fact been taken from the literature on learning. For instance, learned helplessness research (i.e., the procedure by which a sequence of non-contingent then contingent reinforcement or punishment results in decrements in performance [Maier, Seligman, and Solomon, 1969]) suggests that institutionalization and its associated welfare assistance programs, as a form of non-contingent relief, may impede the

patient's return to self-maintenance in the community where contingent reinforcement is the norm.

From this perspective of learned helplessness, placing the severely disturbed person in the "sick role" within the confines of the hospital setting tends to aggravate and compound the problem. Hospitalization officially divests the person of responsibility for solving their personal problems and encourages socio-emotional and economic dependency. It cuts people off from much needed sources of social support, confirms for themselves and others that they are "sick", and often stimulates a cycle of negative self-attributions which may interfere with learning new roles and behaviors. However, this view of dependency-related hospitalization may be as overdeterministic as some medical conceptions of mental illness. It suggests a generalized behavioral deterioration effect resulting from hospitalization. Alternatively, we suggest it may be only certain aspects of hospitalization which tend to encourage dependency and helplessness.

There is some indirect support for this argument of selective hospital induced dependency in relation to the extant research on learned helplessness. While the learned helplessness effect of "fixated behavior" has been demonstrated in both infrahuman and human subjects across a number of stimulus situations, reward systems and idiosyncratic response systems (MacKinnon, 1968; Rashotte and Amsel, 1968; Ross, 1964; Wilcoxon, 1952; Deur and Parke, 1968; Linden, 1974; Marquart, 1948; Marquart and Arnold, 1952; Vogel-Sprott and Thurstone, 1968), such researchers have not systematically investigated the effect across different roles. It may be that the generalizability of the learned helplessness effect with humans depends upon the generalizability of a given role and its role related activities. When individuals who have

previously been exposed to noncontingent reinforcement or punishment in one particular role are shifted to a different and unrelated role, the so-called effect may not be obtained.

The predominant theories of learned helplessness (i.e., expectancy theory, schedule shift, and persistence theory--see Levis, 1980 for a summary discussion), moreover, share a common individualistic bias. Whether we attribute the effect to expectancies, discrimination deficits or to persistent frustration, we nonetheless locate the mechanism explaining the effect within the individual organism, and not within the relationship of the organism to others. A social psychological conception of learned helplessness for humans, on the other hand, attributes the effect to the relationship between people in particular roles. Learned helplessness is viewed as a characteristic of a relationship within certain role networks and not a characteristic of a person. Relationships arise within and are supported by particular social networks, rule-role frameworks, power structures, communication and status systems, etc. An observation which can account for the apparent reluctance of learning theorists to apply the learned helplessness concept to time extended and complex social interaction episodes in various social settings and cultural milieux.

Given the social psychological orientation of the present study, it was assumed that putting individuals into the "sick role", vis a vis diagnosis, treatment, hospitalization and the provision of special support (i.e., welfare), would contribute to the very problem psychiatrists hope to solve. In other words, in the course of being diagnosed as mentally disabled, provided with treatment, and then discharged to some form of subsistence program, an individual would become increasingly dependent and helpless. Once assigned to the sick

role, people begin to view themselves differently and are related to differently by others. They are stripped of their social and economic resources (job, status, security, social supports, etc.) and their autonomy. Thus, by telling a person that he is too sick to care for himself, and divesting him of self-responsibility, he becomes increasingly dependent upon others for the basics of life.

Marlowe (1974), in a study of 429 elderly patients at Modesto State Hospital, found that patients tend to improve the most when their treatment environments maximize autonomy, discourage dependency, and attempt to integrate them back into the community. We also know that both free non-contingent reward and punishment can lead to a state of passivity and helplessness in an otherwise normal organism (Maier et al, 1969; Hulse et al, 1975).

Therefore, based upon these considerations, it was expected that chronic neuropsychiatric patients would report dependency feelings, and these feelings would contribute to their psychiatric problems by positively predicting number of hospital admissions.

The present study also afforded a special opportunity to investigate the feelings and behaviors of chronic neuropsychiatric patients in a sheltered workshop setting. Located on hospital grounds, the sheltered workshop was loosely structured and designed to encourage, and ultimately transition, chronic patients back into jobs and the community. However, the treatment staff did not implement a systematic and "real life-like" program for allocating rewards and punishments in the workshop setting. An implicit assumption shared by most staff members was that getting any work out of such chronic cases would be an indication of improvement. The patients were generally provided the minimum

wage for work performed, minimally supervised, and the work standards were not well-defined.

But prior research (Backman, Secord & Slavitt, 1976) indicates both the strength of reward and coercive power depends upon the magnitudes of reward and punishment involved, and the probabilities of their occurrence. Since the workshop operated with a therapeutic orientation (i.e., free reward, minimal surveilance, improbable punishment or loss of rewards, ambiguous work standards, etc.), it was expected that the patients in the workshop would come to perceive themselves as having a high degree of power in the workshop setting. For in fact they did. Therefore, the social psychology of the work setting should be a more likely predictor of work performance than the apparent disabilities of the patients. The same chronic neuropsychiatric patients who expressed welfare dependency should also express a sense of power, but in relation to their role as a worker in the sheltered workshop. The patients sense of their own power in the workshop should negatively predict their work performance. Very simply, the patient would get paid for trying, regardless of his or her level of performance.

Thus, the purpose of the present study was to investigate concomitant feelings of power and dependency in chronic neuropsychiatric patients arising out of different roles in their lives, with the intent of showing that dependency is role specific, and not a generalized behavior. Self evaluations of dependency were assessed in relation to one real life role (i.e., a mental patient receiving welfare for their disability or "disabled welfare recipient") and then evaluations of estimated power were assessed in relation to another role (i.e., subsidized worker in a sheltered workshop). Additionally, an actual work-related

performance measure was used to assess the extent dependency feelings in one role would be related to actual behaviors in another role.

Methods

Subjects

Fifteen clients participating in a sheltered workshop on mental hospital grounds served as the subjects. All 15 clients were current members of the workshop and made up the total number of psychiatrically disabled clients at the time of the study. Clients admitted to the workshop were either referred from one of the hospital-based neuropsychiatric units or recruited from one of the local group care facilities for discharged mental patients. The workshop clients were predominantly: middle aged (mean=40.1), unmarried, divorced or separated (100%), receiving some form of supplementary assistance (i.e., SSI, welfare, etc.) (81%), receiving medication (88%), indicated multiple hospital admissions (mean=5.3), a long history of psychiatric illness (mean=15.3 years), and diagnosed as some form of schizophrenic on their most recent psychiatric evaluation (69%).

Procedures

Prior to this study, it was indicated that the workshop population was highly transient, difficult to follow-up and relatively small at any given time ($n \leq 20$). Certain structural features (i.e., high client turnover, population size and inadequate personnel) precluded the implementation of more traditional sampling and investigative procedures (i.e., experiment or survey).

Hence the study was initiated when at least 85% of the workshop participants had been continuously in the workshop for two or more months (actually, only one of the subjects had only been in the workshop continuously for less than 2 1/2 months). This procedure was used to insure a certain amount of stability in the workshop membership, and thus familiarity with the norms of the sheltered workshop.

All 15 clients were tested on the behavioral work measure prior to giving their self ratings of dependency and power. Each client was unaware that he/she was being tested and understood the tests to be typical work assignments. The work measures consisted of short duration and long duration tasks (i.e., toilet cleaning--10 minutes--and window washing--60 minutes--respectively).

Shortly after the completion of the work measures, each client met privately with a primary therapist at a designated time. The primary therapist explained that the workshop staff was attempting to improve the quality of the workshop and therefore a questionnaire was designed to find out about the feelings and experiences of workshop members (both in and out of the workshop). Before beginning the questionnaire, the primary therapist explained the scaling procedures, answered any questions, and clarified any ambiguities. The primary therapist then remained in the room while each client filled out the questionnaire in order to answer any questions that might have arisen spontaneously. Following the administration of the questionnaire, each client was thanked for their help/participation and instructed to return to work.

Each patient was administered a questionnaire which included the following eleven point scales: 1) Do you feel you are dependent upon welfare (definitely, definitely not); and 2) how much power do you feel the clients in the workshop

have (none at all, very much).

Results

Power and dependency ratings were not statistically related to one another ($r=.08$). Additionally, the zero order correlation between the two work tasks was .71 ($p<.01$). Table 1 shows the clients' mean performance for both the short duration and long duration work tasks relative to the work supervisor's performance on the same tasks (i.e., a ten-point scale was used to assess task performance).

Insert Table 1 about here

A regression analysis was then computed to examine the relationship between the clients' dependency feelings on welfare and number of admissions to a mental hospital. Self ratings of welfare dependency positively predicted the number of admissions to a mental hospital ($F=6.02$, $p=.02$) and explained 32% of the variance. As expected, the clients' sense of their power in the sheltered workshop negatively predicted their actual work performance on a short duration work task ($F=6.39$, $p=.02$) and explained 33% of the variance. Clients' power ratings and prescribed prolixin (whether the clients in the workshop were currently receiving some prolixin as part of their medication--yes or no) negatively predicted their work performance on a long duration work task ($F=18.49$, $p=.001$) and explained 75% of the variance. Power ratings explained 46% of the variance while prescribed prolixin explained an additional 29% of the variance. The correlation between

power ratings and prescribed prolixin was -.19 and indicated that these two predictor variables were statistically orthogonal to one another.

Discussion

A significant relationship was obtained between two objective role measures (i.e. number of mental hospital admissions according to hospital records and actual work performance in a sheltered workshop) and two distinct role-related feelings (i.e., dependency and power). Clients' sense of power negatively predicted their work performance whereas clients dependency feelings positively predicted number of hospital admissions. Dependency and power were also found to be statistically independent of one another.

Taken together, these findings provide convincing evidence of dependency as a role-related feeling and not as a generalized behavior. The subjects simultaneously expressed feelings of power and dependency but in relation to different roles in their lives as mental patients. Although prescribed prolixin contributed to the explained variance of the long duration work task, it was by far the greater influence of the clients' sense of power which could explain the greater proportion of variance of both short and long duration work tasks. Thus power feelings were associated with the work role and dependency feelings were associated with the disabled welfare recipient role.

The present study also provides some indirect support for a role theory interpretation of what might be considered a learned helplessness effect in a real life situation. These findings suggest that the learned helplessness effect may be limited to assessed behaviors within the same or similar roles,

role-related tasks or role systems, and thus attributable to the relationship between people in particular roles or role systems. Future research should attempt to systematically investigate the generalizability of the learned helplessness effect across different roles and role networks.

The role theory argument is further supported when we attempt to explain the data in terms of the predominant theories of learned helplessness. Expectancy theory (Maier and Seligman, 1976) predicts a generalized decrement in behavior across roles since the subjects have acquired the expectation that responding and outcome are independent. Discrimination theory, which assumes that helplessness reflects a special case of a schedule-shift effect, does not make differential predictions from expectancy theory (McReynolds, 1980). Both theories cannot explain the present findings. Persistency theory (Amsel, 1972; Levis, 1980), which ties the learned helplessness effect to an initially disruptive emotional event and some ongoing behavior, can, however, make differential predictions from the non-motivational theories of Maier and Seligman, and of McReynolds. For instance, Abramson, Alloy and Rosoff (1981) found that relative to non-depressed college students, depressed college students underestimated their potential control when they had to generate a complex hypothesis for control, but not when the complex hypothesis was generated for them. These findings suggest that chronic neuropsychiatrics might not manifest a learned helplessness response pattern in a sheltered workshop where their work roles and work tasks are generated for them. While this argument is plausible, it cannot account for the following: 1) the majority of the clients in the workshop at any given time were diagnosed as schizophrenic (approximately 70%) and not depressives. The

Abramson et al findings were based on a study of depressed and non-depressed college students, and may not be generalizable to schizophrenics; 2) a consistent finding of experimentally investigated learned helplessness has been the report of increased hostility and frustration following inescapable pretreatment exposure (Hirota and Seligman 1975; Miller and Seligman, 1975). Although the present study did not assess hostility or frustration, it would seem that the clients' belief that they had high power in the workshop would be incompatible with persistent feelings of frustration associated with response non-contingent reinforcement; and 3) it is highly problematic whether the simple work tasks in the present study are equivalent in degree of difficulty to the generation of complex hypotheses in the Abramson et al study.

In sum, the present study has provided some direct evidence of specifically role-related feelings, and has shown these feelings to be independent of each other. These findings also provide some indirect support for a role theory interpretation of learned helplessness-like phenomena, and suggest we seriously question the overdeterministic and individualistic bias of past learned helplessness research. Some roles, relationships and aspects of hospitalization and psychiatric treatment may indeed encourage dependency and learned helplessness. But others may not and actually encourage self mastery, especially in a sheltered workshop setting where specific work norms and goals are established and independence is encouraged. The quandary for clinicians in the mental hospital setting is to identify those roles and role-related behaviors associated with dependency and self mastery, and to insure the patient receives the proper dosage of each at the proper time in order to facilitate their eventual return to the community.

Table 1. The average work performance of the clients on the short and long duration work task (N=15) as a proportion of their work supervisor's performance on the same tasks.

	Mean	SD
Short duration work task (i.e., toilet cleaning)	5.43 (54%)	1.04
Long duration work task (i.e., window washing)	5.62 (56%)	1.02

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